

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

12608 63-049992  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED DEC 27 1963

VS 300  
Rev. 4/59

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2/002

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81

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Clayton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.		d. STREET ADDRESS (If outside, give location) 6418 San Bonita	
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS STEIN		4. DATE OF DEATH Month Day Year Dec. 19, 1963	
5. SEX Male	6. COLOR OR RACE Cauc.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1894
9. AGE (last birthday) 69		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Efram Stein		13b. MOTHER'S MAIDEN NAME Unk.	
14. NAME OF HUSBAND OR WIFE Sarah		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Sarah Stein 6418 San Bonita	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm or Arteriosclerotic heart disease 4200 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1960 to death and last saw him alive on 1963		Death occurred at 11:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE William D. Smith M.D.	22b. ADDRESS 100 N. Euclid St. St. Louis, Mo.	22c. DATE SIGNED 12-20-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 12/20/1963	23c. NAME OF CEMETERY OR CREMATORY Chased Shel Emeth	23d. LOCATION (City, town, or county) University City, Mo.
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. DEC 20 1963	
26. REGISTRAR'S SIGNATURE Road Smith, M.D.			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Lawrence J. Davis*  
Licensed Embalmer No. 3988

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.